

Exhibit 8.1(a)(i)
UMCMC/LCMC/Louisiana State University Collaborative
Cost Analysis Worksheet

		1.	2.	3.	4.
		Medicaid ^(b)	Medicaid Managed Care ^(c)	Uninsured	Total
Program Costs (from annual cost report with adjustments referenced in this worksheet) ^(a)					
1. Inpatient Acute	Wkst. D-1, Line 49 (hospital column)	\$ 66,008,460	\$ 30,211,395	\$ 184,453,719	\$ 280,673,574
2. Inpatient Psychiatric	Wkst. D-1, Line 49 (subprovider column)				\$ -
3. Outpatient Cost Based Outpatient Fee Schedule:	Worksheet D,Pt V, Line 202, Column 6				\$ -
4. Outpatient Surgery	covered program charges X cost-to-charge ratio				\$ -
5. Outpatient Lab	covered program charges X cost-to-charge ratio				\$ -
6. Outpatient Physical Therapy	covered program charges X cost-to-charge ratio				\$ -
7. Outpatient Clinic	covered program charges X cost-to-charge ratio				\$ -
8. Other Fee Schedule Services	covered program charges X cost-to-charge ratio				\$ -
9. Program Costs	Sum of Lines 1 - 8	\$ 66,008,460	\$ 30,211,395	\$ 184,453,719	\$ 280,673,574
10. Less: payments from uninsured patients		XXXXXXXXXXXXX	XXXXXXXXXXXXX		\$ -
11. Required Program Funding	Line 9 less Line 10	\$ 66,008,460	\$ 30,211,395	\$ 184,453,719	\$ 280,673,574
Less DHH Payments:					
12. Total Claims Payment ^(a)		# \$ 31,883,860	\$ 14,594,070		\$ 46,477,930
13. Outliers					\$ -
14. supplemental/lump sum related to line 11				\$ -	\$ -
15. Total payments	Sum of Lines 12 - 14	\$ 31,883,860	\$ 14,594,070	\$ -	\$ 46,477,930
16. Difference = Amount due UMCMC/(State)	Line 11 Less Line 15	\$ 34,124,600	\$ 15,617,325	\$ 184,453,719	\$ 234,195,644
Required Ancillary Program Funding:					
17. Physician and Other Professionals	Exhibit 8.1(i)A - Line 7				\$ 36,131,469
18. Outpatient Pharmacy	Exhibit 8.1(a)(i)A - Line 10				\$ 5,075,409
19. Other Indigent Care Related Program Funding	Exhibit 8.1(a)(i)A - Line 15				\$ 1,686,505
20. Charity Hospital Campus Cost	Exhibit 8.1(a)(i)A - Line 16				\$ 1,196,101
21. Nonreimbursable Accountable Care Services	Exhibit 8.1(a)(i)A - Line 17				\$ -
22. Additional Amount Due LCMC or Affiliates	Sum of Lines 17 - 21				\$ 44,089,484
23. Total Due	Sum of Line 16 +22				\$ 278,285,128

(a) All references to the annual cost report worksheets, schedules, and line items shall include their successor equivalent provisions. Cost report schedules refer to the Medicaid cost report which includes allowable cost of graduate medical education and related teaching cost.

(b) Medicaid includes all Medicaid claims processed and paid by the state which includes traditional fee for service plus all shared savings or other plans paid directly by the state.

(c) Includes all Bayou Health or any other Medicaid managed care contracts that are not included in column 1.

(d) Payments include net amounts received on an interim basis for claims referenced in columns 1 & 2. Includes primary payer payments.

Exhibit 8.1(a)(i)A
UMCMC/LCMC/Louisiana State University Collaborative
Unfunded Cost Worksheet

Current FY Unfunded Cost		
Shortfall on Physicians ^(a)		
1. Physician expense	W/S A-8, Line 10	\$ 33,840,970
2. CRNA expense	W/S A-8, Line 28	\$ 7,880,652
3. Physicians Assistant	W/S A-8, line 29	\$ 677,835
4. Physician billing non-reimbursable	W/S B Part I, line 192.03	\$ 2,217,564
5. Subtotal Physician Cost	Sum Lines 1-4	\$ 44,617,021
6. Less: Net Collections on Professional Fee Billings	Hospital Trial Balance	\$ 8,485,552
7. Shortfall on Physicians	Line 5- Line 6	\$ 36,131,469
Shortfall on Outpatient Pharmacy ^(a)		
8. Outpatient Pharmacy Cost	W/S B Part I, Column 26, line 192.02	+ \$ 5,075,409
9. Outpatient Pharmacy Collections	Hospital Trial Balance	
10. Shortfall on Outpatient Pharmacy	Line 8 - Line 9	\$ 5,075,409
Shortfall on Other Non-Reimbursable cost centers ^(a)		
11. Dental Clinic	W/S B Part I, Column 26, line 192.01	\$ 954,750
12. Mobile Health Unit	W/S B Part I, Column 26, line 193.01	\$ 595,119
13. Disallowed Idle Space	W/S B Part I, Column 26, line 190.02	\$ 72,649
14. New Orleans School Based Clinics	W/S B Part I, Column 26, line 190.03	\$ 63,987
15. Shortfall on other Non-Reimbursable cost centers	Sum of Lines 11-14	\$ 1,686,505
16. Shortfall on Charity Hospital Campus ^(b)		\$ 1,196,101
17. NonReimbursable Accountable Care Service Expense	ACS Cost allocated to NonReimb Cost Centers	
18. Total Cost To Be Paid By State Per CEA	Line 7 + Line 10 + Line 15 + Line 16 + Line 17	\$ 44,089,484

(a) Cost report line numbers reference the cost report from FYE 6/30/2012 (Provider #19-0005) subject to change as line numbers may be reassigned in subsequent years.

(b) Charity campus cost offset on FYE 06/30/2012 cost report on WS A-8 Lines 38.01-38.05. Shortfall to include full cost offset in subsequent periods.

+ Net incremental cost as estimate

Exhibit 8.1(a)(ii)**UMCMC/LCMC/Louisiana State University Collaborative
Shared Cost Savings Incentive****Cost Comparison**

1. Medicaid and Uninsured Inpatient Days	Note 1 W/S S-3 line 14 + Line 16 , Col 7 (all units)
2. Medicaid and Uninsured IP Charges	E-3 part VII, Col 1, Line 12 (all units)
3. Medicaid and Uninsured OP Charges	E-3 part VII, Col 2, Line 12 (all units)
4. Gross Pt. Charges	Sum of Lines 2 - 3
5. Adjusted Patient Days	Line 1 X Line 4 / Line 2
6. Medicaid and Uninsured Cost	Exhibit 8.1(a)(i), line 9 (total)
7. Medicaid and Uninsured GME Cost	D part III + D part IV (IP and OP) ^(b)
8. Medicaid and Uninsured Capital Cost	D part I + D part II (IP and OP)
9. Medicaid and Uninsured Cost of ACS and Business Operations	Allowable ACS cost x (Line 4 / W/S C, Line 200, Col 8)
10. Net Medicaid and Uninsured Operating Cost	Line 6 Less: sum of line 7, 8, 9
11. Operating Cost Per Adjusted Patient Day	Line 10 / Line 5

Part 1 - Payment Eligibility:

12. Base Year Cost per Adjusted Patient Day	Exhibit 8.1(a)(ii)A, Line 11 (or PY Line 14)
13. Market Basket ^(a)	Referenced in Medicare IPPS Annual Final Rule
14. Baseline Cost / APD	Line 12 X (1 + Line 13)
15. Actual Cost / APD	Line 11
16. Eligible for Cost Sharing Incentive	Line 15 < Line 14

Part 2 - Determination of Target Threshold:

17. Base Medicaid and Uninsured cost ^(c)	Budgeted Cost (or Lower of PY Ln 20 or PY Ln 21)
18. Inflation Adjustment	Line 17 X (Line 13)
19. Projected Growth	Per CEA (Article 8)
20. Target Threshold	Sum of Lines 17 - 19

Part 3 - Determination of Incentive Payment:

21. Medicaid and Uninsured Cost - Net of ACS and Bus. Ops.	Line 6 - line 9
22. Does Actual Exceed Threshold (Yes / No)	Line 21 > Line 20?
23. Incentive Offset	If Line 22 = "Yes", Line 21 - Line 20
24. Cost Savings Per Adjusted Patient Day	If Line 16 = True, Sum of Line 14 Less Line 15
25. Adjusted Patient Days	Line 5
26. Volume Adjusted Cost Savings	Line 24 X Line 25
27. Cost in Excess of Target	Line 23
28. Volume Adjusted Cost Savings Available for Incentive	Line 26 Less Line 27
29. Shared Cost Factor	Per CEA Article 8
30. Maximum Incentive Payment	7.5% of actual Cost (Line 21)
31. Shared Cost Incentive Payment From The State	Lower of (Line 28 X Line 29), or Line 30

UMCMC Year 1 SFY 14	UMCMC Year 2 SFY 15
52,706	
306,932,734	
231,819,709	
\$ 538,752,443	\$ -
92,514	-
280,673,574	
39,179,524	
19,549,313	
\$ 221,944,737	\$ -
\$ 2,399.04	\$ -
\$ 2,457.90	\$ 2,612.75
6.30%	3.10%
\$ 2,612.75	\$ 2,693.74
\$ 2,399.04	\$ -
TRUE	TRUE
\$ 280,673,574	\$ 280,673,574
	\$ 8,700,881
	-
\$ 280,673,574	\$ 289,374,455
\$ 280,673,574	\$ -
No	No
\$ -	\$ -
\$ 213.71	\$ 2,693.74
92,514	-
\$ 19,770,954	\$ -
\$ -	\$ -
\$ 19,770,954	\$ -
50.00%	50.00%
\$ 21,050,518	\$ -
\$ 9,885,477	\$ -

(a) Year 1 market basket adjustment from FY12 cost shall include update factors for FY13 (2.6%) and FY14 (TBD).
From CMS Final Rule - Rate of Ceiling Increase for Hospitals Excluded from IPPS

(b) If Option (Option 12) to include GME cost is removed from electronic file, this line will be zero.

(c) Target Threshold represents FY14 annual target threshold. Amount to be prorated for less than full year cost report period.

Exhibit 8.1(a)(ii)A**UMCMC/LCMC/Louisiana State University Collaborative****Baseline Cost - ILH****Cost Comparison****ILH - FYE 6/30/2012 Cost Report or UCC Survey**

		ILH Cost Report ^(a) FYE 6/30/2012
1. Medicaid and Uninsured Inpatient Days	W/S S-3 line 14 + Line 16 , Col 7 (all units)	48,243
2. Medicaid and Uninsured IP Charges	E-3 part VII, Col 1, Line 12 (all units)	297,009,642
3. Medicaid and Uninsured OP Charges	E-3 part VII, Col 2, Line 12 (all units)	224,325,010
4. Gross Pt. Charges	Sum of Lines 2 - 3	\$ 521,334,652
5. Adjusted Patient Days	Line 1 X Line 4 / Line 2	84,680
6. Medicaid and Uninsured Cost	D-1, Ln 49 + D pt 5 Ln 202 -Cost columns (all units)	\$ 255,910,867
7. Medicaid and Uninsured GME Cost	D part III + D part IV (IP and OP) ^(b)	37,964,655
8. Medicaid and Uninsured Capital Cost	D part I + D part II (IP and OP)	9,811,597
9. Medicaid and Uninsured Cost of ACS and Bus. Ops.	Allowable ACS cost x (Line 4 / W/S C, Line 200, Col 8)	
10. Medicaid and Uninsured Operating Cost	Line 6 Less Line 7, 8, 9	\$ 208,134,615
11. Operating Cost Per Adjusted Patient Day	Line 10 / Line 5	\$ 2,457.90

(a) The base year refers to Provider #19-0005 for the Fiscal Year Ended 6/30/2012 Medicaid cost report (revised 1/24/2012).
Base Year subject to revision after audit.

(b) If Option (Option 12) to include GME cost is removed from electronic file, this line will be zero.